DME Face-to-Face Rule Quick Reference Fact Sheet

As a result of a new CMS rule, physicians ordering certain durable medical equipment must provide documentation in the patient's medical record a *Face-to-Face* encounter with the patient. ***This encounter must take place during the 6 months prior to the written order for the item.***

CMS requires that for Specified Covered Items ***payment may only be made if a physician has provided the supplier with a written order for the item before the delivery of the item.***

For many items of DME, a physician must document that a physician, a physician assistant (PA), a nurse practitioner (NP), or a clinical nurse specialist (CNS) has had a face-to-face encounter with the beneficiary pursuant to that order.

The patient's ***medical record must contain*** sufficient documentation of the patient's medical condition to substantiate the necessity for the type and quantity of items ordered and ***must be signed by the ordering physician.***

Documentation Requirements

- ☐ Duration of patient's condition
- ☐ Clinical course
- ☐ Prognosis
- ☐ Nature and extent of functional limitations
- ☐ Other Therapeutic interventions and results

Key Items to Address

- ☐ Why does the patient require the item?
- ☐ Do the physical examination findings support the need for the item?
- ☐ Signs and symptoms that indicate the need for the item.
- ☐ Diagnoses that are responsible for these signs and symptoms.
- ☐ Other diagnoses that may relate to the need for the item.

Documentation Tips

- ☐ The information must not be recorded in vague and subjective terms.
- ☐ The information must provide objective measures, tests or observations.
- ☐ Each medical record is expected to be individualized to the unique patient.

Quick Reference Fact Sheet

Important Facts

CMS expects that the patient's medical records will reflect the need for the item ordered. The patient's medical records include:

- ☐ Physician's office records
- ☐ Hospital records
- ☐ Nursing home records
- ☐ Home health agency records
- ☐ Records from other healthcare professionals
- ☐ Test results

Other stipulations of the rule include:

- ☐ A prescription is not considered a part of the medical record.
- ☐ Supplier-produced records, even if signed by the ordering physician, and attestation letters are not considered by Medicare as part of the medical record.
- ☐ Templates and forms, including CMNs, are subject to corroboration with information documented in the patient's medical record.
- ☐ Only a physician can document that the face-to-face encounter occurred
- ☐ Signature and date stamps are not allowed
- ☐ Multiple items can be supported by a single face-to-face encounter, so long as each item's medical necessity is documented in the patient's medical record.

Physician Compensation

CMS has established a G-Code (G0454) to compensate physicians who document that a Physician's Assistant, Nurse Practitioner, or Clinical Nurse Specialist performed the face-to-face encounter.

This G-Code does not apply when a physician bills an evaluation and management code when the physician performs the face-to-face encounter himself/herself.

The G-Codes may only be used when the physician documents a face-to-face encounter that is performed by a PA, NP or CNS.

If multiple orders for covered items originate from one face-to-face encounter, the physician is only eligible for the G-Code payment once.